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AN ACT

D.C. ACT 13-287

Codification District of Columbia Code 2001 Supp.

IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

FEBRUARY 23, 2000

To protect applicants for long-term care insurance from unfair or deceptive sales or enrollment practices, to establish standards for the long-term care insurance industry, to facilitate public understanding and comparison of long-term care insurance policies, and to facilitate flexibility and innovation in the development of long-term care insurance coverage.

BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA, That this act may be cited as the "Long -Term Care Insurance Act of 2000".

New Chapter 49, Title 35

Sec. 2. Definitions.

For the purposes of this act, the term:

New § 35-4901

(1) "Applicant" means:

(A) In the case of an individual long-term care insurance policy, the person who seeks to contract for benefits; and

(B) In the case of a group long-term care insurance policy, the proposed certificate holder.

(2) "Certificate" means any certificate issued under a group long-term care insurance policy, which policy has been delivered or issued for delivery in the District of Columbia.

(3) "Commissioner" means the Commissioner of the District of Columbia Department of Insurance and Securities Regulation.

(4) "Group long-term care insurance" means a long-term care insurance policy which is delivered or issued for delivery in the District of Columbia and issued to one of the following groups:

(A) One or more employers or labor organizations, a trust or the trustees of a fund established by one or more employers or labor organizations, or a combination thereof, for employees or former employees, or a combination thereof or for members or former members, or a combination thereof, of the labor organizations;

(B) Any professional, trade, or occupational association for its members, former or retired members, or combination thereof, if such association:

(i) Is composed of individuals all of whom are or were actively engaged in the same profession, trade, or occupation; and

(ii) Has been maintained in good faith for purposes other than obtaining insurance;

(C) An association, trust, or the trustee of a fund established, created, or maintained for the benefit of members of one or more associations;

(D) Any other group, provided that, the Commissioner finds the following:

(i) The issuance of the group policy is not contrary to the best interest of the public;

(ii) The issuance of the group policy would result in economies of acquisition or administration; and

(iii) The benefits are reasonable in relation to the premiums charged.

(5)(A) "Long-term care insurance" means any insurance policy or rider advertised, marketed, offered, or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis; for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services provided in a setting other than an acute care unit of a hospital. "Long-term care insurance" includes group and individual annuities and life insurance policies or riders which provide directly, or which supplement, long-term care insurance. "Long-term care insurance" also includes a policy or rider which provides for payment of benefits based upon cognitive impairment or the loss of functional capacity.

(B) "Long-term care insurance" shall not include any insurance policy which is offered primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income or related asset-protection coverage, accident only coverage, specified disease or specified accident coverage, or limited benefit health coverage. With regard to life insurance, "long-term care insurance" shall not include life insurance policies which accelerate the death benefit specifically for one or more of the qualifying events of terminal illness, medical conditions requiring extraordinary medical intervention, or permanent institutional confinement and which provide the option of a lump-sum payment for those benefits and in which neither the benefits nor the eligibility for the benefits is conditioned upon the receipt of long-term care.

(6) "Nonforfeiture benefit" means a benefit provided to a policyholder in the event of nonpayment of a premium due.

(7) "Policy" means any policy, contract, subscriber agreement, rider or endorsement delivered or issued for delivery in the District of Columbia by an insurer, fraternal benefits society; nonprofit health, hospital, or medical service corporation; prepaid health plan, health maintenance organization, or any similar organization.

New § 35-4902

Sec. 3. Scope.

(a) Any policy or rider advertised, marketed, or offered as long-term care or nursing home insurance delivered or issued for delivery in the District of Columbia shall comply with the provisions of this act.

(b) This act is not intended to supersede the obligations of entities subject to this act to comply with the substance of other applicable insurance laws insofar as they do not conflict with this act; except that, this act shall supersede laws and regulations designed and intended to apply to Medicare supplement insurance policies.

(c) The requirements of this act shall apply to policies delivered or issued for delivery in the District of Columbia on or after the effective date of this act.

New § 35-4903

Sec. 4. Long-term insurance; who may issue.

Long-term care insurance may be issued by insurers, fraternal benefit societies, nonprofit health, hospital, and medical service corporations, prepaid health plans, and health maintenance organizations, and any similar organization to the extent they are otherwise authorized to issue life or health insurance. Any product advertised, marketed, or offered as long-term care insurance shall be subject to the provisions of this act.

New § 35-4904

Sec. 5. Group policies issued in other states.

No group long-term care insurance coverage may be offered to a resident of the District of Columbia under a group policy issued in another state to a group described in section 2(4)(D), unless the District of Columbia, or another state having statutory and regulatory long-term care insurance requirements substantially similar to those adopted in the District of Columbia has made a determination that such requirements have been met.

New § 35-4905

Sec. 6. Standards for long-term care insurance.

(a) No long-term care insurance policy shall:

(1) Be cancelled, not renewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder;

(2) Contain a provision establishing a new waiting period in the event existing coverage is converted to, or replaced by, a new or other form of coverage within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or

(3) Provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

(b)(1) No long-term care insurance policy or certificate, other than a policy or certificate thereunder issued to a group as described in section 2(4)(A), shall contain a definition of "preexisting condition" which is more restrictive than the following definition: "A condition for which medical advice or treatment was recommended by, or received from a provider of health care services, within 6 months preceding the effective date of coverage of an insured person."

(2) No long-term care insurance policy or certificate, other than a policy or certificate thereunder issued to a group as described in section 2(4)(A), may exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within 6 months following the effective date of coverage of an insured person.

(3) The Commissioner may extend the limitation periods set forth in paragraphs (1) and (2) of this subsection as to specific age group categories in specific policy forms if the Commissioner finds that the extension is in the best interest of the public.

(4) Nothing in this act shall be construed to prohibit an insurer from using an application form designed to elicit the complete health history of an applicant and, on the basis of the answers on that application, from underwriting in accordance with that insurer's established underwriting standards. Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in paragraph (2) of this subsection expires. No long-term care insurance policy or certificate may exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions beyond the waiting period described in paragraph (2) of this subsection.

(c)(1) No long-term care insurance policy may be delivered or issued for delivery in the District if such policy:

(A) Conditions eligibility for any benefits on a prior hospitalization requirement;

(B) Conditions eligibility for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or

(C) Conditions eligibility for any benefits other than waiver of premium, post-confinement, post-acute care or recuperative benefits on a prior institutionalization requirement.

(2)(A) A long-term care insurance policy containing post-confinement post-acute care, or recuperative benefits shall clearly label in a separate paragraph of the policy or certificate entitled "Limitations or Conditions on Eligibility for Benefits" such limitations or conditions, including any required number of days of confinement.

(B) A long-term care insurance policy or rider which conditions eligibility of noninstitutional benefits on the prior receipt of institutional care shall not require a prior institutional stay of more than 30 days.

(3) No long-term care insurance policy or rider which provides benefits only following institutionalization shall condition such benefits upon admission to a facility for the same or related conditions within a period of less than 30 days after discharge from the institution.

(d)(1) Applicants for long-term care insurance shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason.

(2) Long-term care insurance policies and certificates shall have a notice prominently printed on the first page or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, other than a certificate issued pursuant to a policy issued to a group defined in section 2(4)(A), the applicant is not satisfied for any reason.

(3) If an application for a long-term care contract is denied, the issuer shall refund to the applicant any premium and any other fees submitted by the applicant within 30 days of the denial.

Sec. 7. Disclosure.

New § 35-4906

(a)(1) An outline of coverage, written at a fifth grade reading level, shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the recipient to the document and its purpose.

(2) When an agent solicits individuals to purchase long-term care insurance, the agent must deliver the outline of coverage before the presenting of an application or enrollment form to the person being solicited to make a purchase.

(3) In the case of direct response solicitations, the outline of coverage must be presented no later than when any application or enrollment form is presented.

(b) The outline of coverage shall include the following:

(1) A description of the principal benefits and coverage provided in the policy;

(2) A statement of the principal exclusions, reductions, and limitations contained in the policy;

(3) A statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium (continuation or conversion provisions of group coverage shall be specifically described);

(4) A statement that the outline of coverage is a summary only, not a contract of insurance, and that the policy or group master policy contains governing contractual provisions;

(5) A description of the terms under which the policy or certificate may be returned and the premium refunded;

(6) A brief description of the relationship of cost of care and benefits; and

(7) If the policy or certificate is intended to be a long-term care insurance contract, a statement that discloses to the policyholder or certificate holder that the policy is intended to be a long-term care insurance contract.

(c) In the case of a policy issued to a group described in section 2(4)(D), an outline of coverage shall not be required to be delivered, provided that, the information described in subsection (e) of this section is contained in other materials relating to enrollment. Upon request, these other materials shall be made available to the Commissioner.

(d) A certificate issued pursuant to a group long-term care insurance policy which is delivered or issued for delivery in the District of Columbia shall include the following:

(1) A description of the principal benefits and coverage provided in the policy;

(2) A statement of the principal exclusions, reductions, and limitations contained in the policy; and

(3) A statement that the group master policy determines governing contractual provisions

(e) At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy which provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary either upon the applicant's request, or the time of policy delivery, whichever occurs later. In addition to complying with all other applicable requirements, the summary shall also include:

(1) An explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;

(2) An illustration of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits, for each covered person, if any;

(3) Any exclusions, reductions, and limitations on benefits of long-term care; and

(4) If applicable to the policy type, the following:

(A) A disclosure of the effects of exercising other rights under the policy;

(B) A disclosure of guarantees related to long-term care costs of insurance charges, and

(C) Current and projected maximum lifetime benefits.

Sec. 8. Minimum number of members for associations. New § 35-4907

(a) Prior to advertising, marketing, or offering a group long-term care insurance policy within the District of Columbia, an association or associations, or an insurer of the association or associations, shall file evidence with the Commissioner that the association, or associations, has

(1) At the outset, a minimum of 100 members;

(2) Been organized and maintained in good faith for purposes other than that of obtaining insurance;

(3) Been in active existence for at least one year; and

(4) A constitution and bylaws which provide the following:

(A) That the association or associations hold regular meetings not less than annually to further the purposes of the members;

(B) That, except for credit unions, the association or associations collect dues or solicit contributions from members; and

(C) That the members have voting privileges and representation on the governing board and committees.

(b) Thirty days after the filing required by subsection (a) of this section, the association or associations shall be deemed to have satisfied the organizational requirements of subsection (a) of this section unless the Commissioner makes a finding that the association, or associations, does not satisfy the organizational requirements.

Sec. 9. Monthly reports. New § 35-4908

Any time a long-term care benefit which is funded through a life insurance vehicle by the acceleration of the death benefit is in benefit payment status, a monthly report shall be provided to the policyholder. The monthly report shall include the following:

(1) Any long-term care benefits paid out during the month;

(2) An explanation of any changes in the policy (e.g., death benefits or cash values due to long-term care benefits being paid out); and

(3) The amount of long-term care benefits existing or remaining.

Sec. 10. Incontestability period. New § 35-4909

(a) If a policy or certificate has been in force for less than 6 months, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is material to the acceptance for coverage.

(b) If a policy or certificate has been in force for at least 6 months, but less than 2 years, an insurer may rescind a long-term care insurance policy or certificate or deny an otherwise valid long-term care insurance claim upon a showing of misrepresentation that is both material to the acceptance for coverage and which pertains to the condition for which benefits are sought.

(c) After a policy or certificate has been in force for 2 years, it shall not be contestable upon the grounds of misrepresentations alone The policy or certificate may be contested only upon a showing that the insured knowingly and intentionally misrepresented relevant facts relating to the insured's health.

(d)(1) No long-term care insurance policy or certificate may be field issued based on medical or health status.

(2) For purposes of this subsection, the term "field issued" means a policy or certificate issued by an agent or a third-party administrator pursuant to the underwriting authority granted to the agent or third party administrator by an insurer.

(e) If an insurer has paid benefits under a long-term care insurance policy or certificate, the benefit payments may not be recovered by the insurer in the event that the policy or certificate is rescinded

(f)(1) In the event of the death of the insured, this section shall not apply to the remaining death benefits of a life insurance policy that accelerates benefits for long-term care.

(2) This section shall apply to life insurance policies that accelerate benefits for long term care, except that, in the event of death of the insured, the remaining death benefits under these policies shall be governed by section 3 of An Act Respecting contracts of industrial life insurance in the District of Columbia, approved June 4, 1934 (48 Stat. 834; D.C. Code § 35-903)

Sec 11 Nonforfeiture benefits

New § 35-4910

(a) Except as provided in subsection (b) of this section, a long-term care insurance policy may not be delivered or issued for delivery in the District of Columbia unless the policyholder or certificate holder has been offered the option of purchasing a policy or certificate including a nonforfeiture benefit The offer of a nonforfeiture benefit may be in the form of a rider that is attached to the policy In the event the policyholder or certificate holder declines the nonforfeiture benefit, the insurer shall provide a contingent benefit upon lapse that shall be available for a specified period of time following a substantial increase in premium rates.

(b) When a group long-term care insurance policy is issued, the offer required in subsection (a) of this section shall be made to the group policyholder. If, however, the policy is issued as group long-term care insurance as described in section 2(4)(D), other than to a continuing care retirement community or other similar entity, the offering shall be made to each proposed certificate holder

(c) The Commissioner shall promulgate regulations specifying the type or types of nonforfeiture benefits to be offered as part of long-term care insurance policies and certificates, the standards for nonforfeiture benefits, and the rules regarding a contingent benefit upon lapse, including a determination of the specified period of time during which a contingent benefit upon

lapse will be available and the substantial premium rate increase that triggers a contingent benefit upon lapse as described in subsection (a) of this section.

New § 35-4911

Sec. 12. Rules and regulations.

The Commissioner may issue rules to implement any provision of this act. The rules may include:

(1) Requirements for any disclosure made under this act, including the manner, content, and required disclosures for the sale of long-term care insurance policies, terms of renewability, initial and subsequent conditions of eligibility, nonduplication of coverage provisions, coverage of dependents and preexisting conditions, termination of coverage, continuation or conversion of coverage, probationary periods, limitations, exceptions, reductions, elimination periods, requirements for replacement, recurrent conditions, and definitions;

(2) Loss ratio standards specifically applicable to long-term care insurance policies;

(3) A standard format, which may include a description of the style, arrangement, overall appearance, and the content of an outline of coverage; and

(4) Minimum standards for marketing and reporting practices for long-term care insurance.

New § 35-4912

Sec. 13. Penalties.

In addition to any other penalties provided by law, if, after a judicial proceeding or an administrative proceeding conducted in accordance with title I of the District of Columbia Administrative Procedure Act, approved October 21, 1968 (82 Stat. 1203; D.C. Code § 1-1501 *et seq.*), any insurer or any agent is found to have violated any requirements of this act, that insurer or agent shall be subject to a fine of up to 3 times the amount of any commissions paid for each policy involved in the violation or up to $10,000, whichever is greater.

Sec. 14. Fiscal impact statement.

The Council adopts the fiscal impact statement in the committee report as the fiscal impact statement required by section 602 (c)(3) of the District of Columbia Home Rule Act, approved December 24, 1973 (87 Stat. 813; D.C. Code section 1-233 (c)(3)).

Sec. 15. Effective date.

This act shall take effect following approval by the Mayor (or in the event of veto by the Mayor, action by the Council to override the veto), approval by the Financial Responsibility and Management Assistance Authority as provided in section 203 (a) of the Financial Responsibility

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and Management Assistance Act of 1995, approved April 17, 1995 (109 Stat. 116; D.C. Code § 47-302.3(a)), a 30-day period of Congressional review as provided in section 602 (c)(1) of the District of Columbia Home Rule, approved December 24, 1973 (87 Stat. 813; D.C. Code Sec. 1-233 (c)(1)), and publication in the District of Columbia Register.

Chairman
Council of the District of Columbia

Mayor
District of Columbia
APPROVED: February 23, 2000